Attn: Medical Marijuana Program
DHHS Division of Licensing and Regulatory Services
11 State House Station
Augusta, ME 04333

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

John E. Baldacci, Governor Brenda M. Harvey, Commissioner

Medical Use of Marijuana Program
Application/Renewal Form

This application is for: (check all that apply)

☐ Patient Registration ☐ Primary Caregiver Registration ☐ Dispensary Selection

☐ MaineCare Member MaineCare #: _____

Section 1

Name of patient (last, first, middle initial)

Home Address
(number and street name)
(not required if homeless)

(city, state, zip code)

Telephone: (207) -

Mailing Address

(city, state, zip code)

I apply to:

☐ Grow my marijuana

☐ Primary caregiver will grow marijuana

☐ Obtain marijuana from a registered dispensary

Name of registered dispensary, if selected:

Grow Location

Date of Birth:_____ Driver License Number: _____ Attach copy of Driver License

If under 18 years of age, complete Section 2

Section 2 TO BE COMPLETED FOR MINOR APPLICANT in SECTION 1 OR PERSON UNDER GUARDIANSHIP OR DURABLE POWER OF ATTORNEY

Parent/guardian/other name (last, first, middle initial) as it appears on your driver's license

Telephone number if different than above

(207) -

Mailing Address if different than patient

☐ Parent with legal authority to make medical decisions

☐ Legal Guardian (attach copy)

☐ Durable Power of Attorney (attach copy)

Attach copy of Driver License

Driver License Number: _____

Date of Birth: _____

Section 3 PRIMARY CAREGIVER (other than a Registered Dispensary)

Name (last, first, middle initial) as it appears on your driver's license, or legal name Telephone number: (207) -

Home Address

(street)

(city, state, zip code)

Mailing Address

(city, state, zip code)

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Date of Birth:_____ (Must be 21 or older) Driver's License Number (attach copy):

☐ Attached signed release of information

Primary caregiver must complete this section to describe the nature of the assistance to this qualified patient (e.g. growing, transporting, cultivating, controlling acquisition, determining the dosage and frequency of the medical use, assisting the patient to administer)

If hospice or nursing home, attach separate sheet for each staff person with caregiver responsibility.

If growing marijuana for a registered qualifying patient, at what address:

☐ Check if hospice	☐ Check if custodial parent, relative or guardian
☐ Check if nursing home	☐ Other

Declaration: I/we understand and acknowledge my/our duties as patients and primary caregivers. I/we understand that if the patient's identification card expires or is revoked, then the primary caregiver identification card is null. I/we agree to return the registration cards to the Department of Health and Human Services under those circumstances. If the patient chooses another caregiver, the caregiver card will be null and void and will be returned to the Department of Health and Human Services. I/we declare under penalty of perjury that the information provided on this form is true and correct. I/we certify that I/we will not sell, furnish or give marijuana to a person who is not allowed to possess marijuana for medical purposes. If I grow and cultivate marijuana for medical use, I agree to have my enclosed, locked facility be inspected by representatives of the Maine Department of Health and Human Services. I agree to provide soil and product samples to representatives of the Maine Department of Health and Human Services for testing pursuant to the rules governing Maine's Medical Marijuana Program. I further agree tha

Printed name of primary caregiver/hospice director/nursing home director

Signature Date

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Printed name of patient

Date

Signature of patient

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For Hospice or Nursing Home Use: List all Employees who will need a registration card to fullfill caregiver duties under the Maine Medical Use of Marijuana Program:

Name	Title	Driver License #	Date of Birth

Note: A copy of the driver's license for each employee is required to be submitted with this application.